JULY 2006 HEALTHY FAMILIES PROGRAM
ANNUAL REPORT SUPPLEMENT

In compliance with Title XXI of the Social Security Act (Section 2108(a), the Managed Risk Medical Insurance Board (MRMIB) is required to submit an annual report ("the Federal Annual Report") to the Centers for Medicare and Medicaid Services assessing California's operation of the State Children's Health Insurance Program (SCHIP). MRMIB submits a copy of this report to the Legislature with a supplement containing additional information pursuant to Insurance Code Section 12693.92(b). Specifically, Section 12693.92(b) requests information regarding:

- The provision of preventive services by health plans and health care providers.
- The performance of health plans and providers in providing preventive services and addressing barriers to service delivery.
- The mechanisms that will be used to identify changes over time in the health status of children enrolled in the program along with the provision of information regarding changes in health status for children enrolled in the program.

The information presented below supplements MRMIB's submission of the 2005 Federal Annual Report to the Legislature and highlights key areas presented in the 2005 Federal Annual Report (enclosed) and the report's attachments:
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Attachment I: California Health Interview Survey
Attachment II: Open Enrollment 2005 Survey Report.
Attachment III: Healthy Families Program 2004 Report of Consumer Survey of Health Plans
Attachment IV: Healthy Families Program 2004 Report of Consumer Survey of Dental Plans
Attachment V: 2004 Annual Retention Report
Attachment VI: Healthy Families Program Health Status Assessment (PedsQL™) 2004

The report and its attachments can be found at:
http://www.mrmib.ca.gov/MRMIB/HFP/Fed05AnnualRpt.pdf

PERFORMANCE OF HEALTH PLANS AND PROVIDERS IN PROVIDING PREVENTIVE SERVICES

To assure the provision of preventive services by health plans and health providers, MRMIB continues to use methods first outlined in its July 2000 Annual Report to the Legislature. These methods include contractually requiring participating health plans to provide information regarding preventive services to subscribers, and monitoring plan performance in the provision of preventive services.

Participating Plan Contract Requirements

The Healthy Families Program (HFP) health plan contracts require plans to provide the medical services outlined in the program regulations. Periodic health exams, prenatal

care, immunizations, well care visits, vision and hearing testing, as well as effective health education are examples of the preventive services included in the regulations. Preventive services, including immunizations, must be provided according to guidelines of the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices. Plans cannot charge co-payments for preventive services.

Informational Materials

Plans supply subscribers/applicants with informational materials to assure that families are aware of the AAP recommended schedule of preventive care and to encourage families to obtain preventive services. Each enrolled family receives a member guide that includes the AAP guidelines for preventive services, including an immunization schedule. This information is available in eleven languages. In addition, the health plans' Evidence of Coverage Booklets provide subscribers with information about the importance of obtaining preventive services, how to use plan benefits, how to access providers, and where to call for questions.

Monitoring Provision of Preventive Services

MRMIB monitors plan performance in the provision of preventive services through quality reports (based on the Health Plan and Employer Data Information Set (HEDIS®) submitted by the plans. The most recent HEDIS Report is attached and can also be found on the MRMIB website: http://www.mrmib.ca.gov/MRMIB/HFP/HEDIS04.pdf.

Results from the report for services provided in 2004 are summarized below.

Measure Description	Healthy Families Program Score 2002 Calendar Year	Healthy Families Program Score 2003 Calendar Year	Healthy Families Program Score 2004 Calendar Year	Medi-Cal Managed Care Score 2004 Calendar Year	NCQA National Average Commercial Results 2004 Calendar Year	NCQA National Average Medicaid Results 2004 Calendar Year
Childhood Immunization Status						
Combination 1*	72%	74%	**75%**	65%	76%	65%
Combination 2*	69%	70%	**75%**	64%	73%	63%
Well-Child Visits in the 3rd Through 6th Years of Life	63%	67%	**68%**	66%	Not Included in Report	Not Included in Report
Adolescent Well-Care Visits	34%	36%	**37%**	34%	Not Included in Report	Not Included in Report
Children's Access to Primary Care Practitioners						
Cohort 1 (Ages 12 - 24 Months)	93%	92%	**91%**	Not Included in Medi-Cal Report	Not Included in Report	Not Included in Report
Cohort 2 (Ages 25 Months - 6 Years)	85%	83%	**82%**			
Cohort 3 (Ages 7 - 11 Years)	83%	83%	**81%**			

* Combination 1 includes age appropriate vaccinations for diphtheria/tetanus/pertussis, polio, measles/ mumps/rubella, H. influenza type B, and Hepatitis B. Combination 2 includes all age appropriate vaccinations in Combination 1 and the chicken pox vaccine.

Consistent improvement is shown in the percentage of eligible children receiving preventive services such as immunizations and well care visits. The HFP continues to

perform at levels above Medi-Cal and national Medicaid benchmarks for these preventive services.

A detailed description about the measures and results by ethnicity, primary language of the applicant, and by participating health plan can be found on the MRMIB website: http://www.mrmib.ca.gov/MRMIB/HFP/HEDIS04.pdf.

PERFORMANCE OF HEALTH PLANS AND PROVIDERS IN ADDRESSING BARRIERS TO SERVICE DELIVERY

Ensuring Access to Providers

Adequate Network of Providers

Health plans provide an adequate network of providers to ensure subscribers have access to medical services. The Department of Managed Health Care and the Department of Insurance regulate health plans that participate in the HFP. Health plans must comply with accessibility requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene). Knox -Keene mandates a ratio of approximately one full-time equivalent primary care physician for each two thousand enrollees. In addition to the regulatory requirements, health plans must annually report the number of primary care physicians (PCPs) that are included in their network, and the percentage of PCPs who are accepting new patients. MRMIB reviews this information during the annual contract rate negotiation process, during which time MRMIB addresses any concerns.

In the 2004-05 benefit year, plans reported that the percentage of PCPs accepting new patients averaged 90.4 percent. For the 2003-04 benefit year, plans reported a 90.2 percent average rate. These rates demonstrate that participating plans continue to maintain adequate networks of providers which ensure HFP subscribers have accessibility to medical services.

Rural Health Demonstration Projects

The Rural Health Demonstration Project (RHDP) enhances access to medical services by addressing barriers experienced by children living in rural areas of the state and children in migrant and seasonal worker families. The RHDP continues to increase access to health, dental, and vision care through two strategies: 1) the Geographic Access strategy funds projects in geographically isolated communities, and 2) the Special Populations strategy funds projects in communities with underserved populations such as migrant seasonal farm workers, American Indians and fishing and forestry workers.

Assembly Bill 1763, Chapter 230, Statutes of 2003 reauthorized the RHDP. The reauthorization required approval of a State Plan Amendment by the Centers for Medicare and Medicaid Services (CMS) which MRMIB received on March 11, 2004. At that time, MRMIB approved 35 projects that began operating during the last quarter of FY 2003-04. The Legislature authorized additional funding in 2005 and 21 more projects

received funding for FY 2005-06 and FY 2006-07. Currently there are 56 projects in operation.

Cultural & Linguistic Services

Participating plans must undertake numerous activities to provide culturally and linguistically appropriate services to address potential barriers to subscribers receiving preventive services. These activities include:

- Informing subscribers of the availability of linguistic services;
- Providing interpreter services for all limited English proficient subscribers seeking health services;
- Maintaining a website that identifies and reports the on-site linguistic capabilities of providers and provider office staff, as well as the distance to a given provider's office;
- Encouraging subscribers to choose culturally and linguistically appropriate providers;
- Translating written informational materials for subscribers; and
- Developing internal systems that meet the cultural and linguistic needs of subscribers.

MRMIB assesses how plans meet the HFP subscribers' needs related to language access and culturally appropriate services through the review of special reports prepared by the plans. MRMIB also reviews grievances and member complaints to identify language barrier problems.

Special Reports

1. Cultural and Linguistic Services Report

   The Cultural and Linguistic Services Report (C & L Report) outlines how plans fulfill the contractual requirements to provide culturally and linguistically appropriate services to subscribers. The C & L Report also includes an update of the activities and/or services the plans proposed to implement as a result of the Group Needs Assessment Report.

2. Group Needs Assessment

   In June 2001, plans submitted a baseline Group Needs Assessment Report (GNA), which identified subscribers' unique perceptions about their health care needs based on their cultural beliefs and practices. The GNA also evaluated community resources for providing health education and cultural and linguistic services and the adequacy of the provider network. Based on the results of this initial GNA, each participating plan developed a work plan of activities designed to address the needs identified in the GNA. Participating plans report the status of their work plan in their annual C & L Report. Plans will complete a new GNA by June 30, 2007. Each plan must assess the internal systems it has in place to address the cultural and linguistic needs of its HFP enrollment population via

internal data (including complaints and grievances, results from member surveys, diversity and language ability of staff, internal policies and procedures, education and training of staff and providers regarding cultural and linguistic competency issues), as well as utilization and outcome data analyzed by race, ethnicity and primary language. Each plan shall also provide an opportunity for representatives of subscribers enrolled in the HFP to provide input on the Needs Assessment.

3. Quality Measurement (HEDIS) Report:

   The 2004 Quality Measurement Report suggests that disparities in access to health care across ethnic and linguistic groups are not present in the HFP. The 2003 C & L Report's findings support this by showing that participating plans have implemented activities to address certain cultural and linguistic needs of their subscribers. MRMIB, participating plan, and advocates will continue to dialog on how any barriers associated with C & L can be further addressed.

Further detailed HEDIS information can be found on the MRMIB website: http://www.mrmib.ca.gov/MRMIB/HFP/HEDIS04.pdf.

MECHANISMS USED TO IDENTIFY CHANGES OVER TIME IN THE HEALTH STATUS OF CHILDREN ENROLLED IN THE HEALTHY FAMILIES PROGRAM

While it is reasonable to presume that improved access to care would affect the health status of children in a positive manner, MRMIB (with funding from the Packard Foundation) has been able to document the connection between access to care and positive changes in health status through a special project. MRMIB implemented a longitudinal survey of families of children who were newly enrolled in the HFP in 2001 to measure changes in access to care and health status among these children over two years of enrollment. The project demonstrated a link between health insurance, health care access and health status. Prior to this project, no such link had been established for children in the United States. Results from this project showed:

- Access to care increased significantly for all children, including children in the most need of medical care.

  Changes in presence of a personal physician, problems getting needed care and foregone health care for children with scores in the lowest and top three quartiles at Baseline who remained in the program for 2 years

	Lowest Quartile			Top Three Quartiles		
	Baseline	Year 1	Year 2	Baseline	Year 1	Year 2
Received foregone health care	25.0%	14.9%	12.1%	15.3%	7.5%	6.2%
Child had a personal physician	52.4%	61.6%	60.7%	58.4%	69.0%	68.0%
Child had problems getting needed care	29.0%	23.0%	22.0%	18.4%	15.7%	14.4%

Of note is that there was continuous improvement over time in the ability of children to access care.

- Improvements in the health status of the population at large.

  - The improvement for the general population of children was not huge (2-3 points), because most children were healthy when they entered the program. However, the fact that the improvement occurred in a large community sample demonstrates that HFP contributes in a meaningful way to the health of a large population of children.

- Dramatic, sustained improvements in health status for the children in the poorest health.

  - The most significant improvements in health status occurred for children in the lowest quartile after one year of enrollment in the program. These gains were sustained through the second year of enrollment. Some improvement in health status for the lowest ranked quartile could occur over time, regardless of participation in HFP. However, the degree of improvement (over 12 points) is dramatic and material.

Changes in PedsQL™ Scores from Baseline to Year 1 and Year 2 in Children with Baseline Scores in the Lowest Quartile

Scores	Baseline n= 862*	Year 1	Change from Baseline to Year 1	Year 2	Change from Year 1 to Year 2	Net Change
Total	58.26	71.27	13.01	70.70	-0.57	12.44
Standard Deviation	(9.33)	(16.73)	-----	(17.01)	-----	----
Physical	54.51	70.84	16.33	71.15	.31	16.64
Standard Deviation	(17.88)	(22.71)	-----	(22.92)	-----	----
Psychosocial	60.31	71.00	10.69	70.41	-0.59	10.10
Standard Deviation	10.48	16.53	-----	16.46	-----	----
Emotional	66.67	72.05	5.38	71.73	-0.32	5.06
Standard. Deviation	18.28	18.75	----	18.62	----	----
Social	57.37	71.59	14.22	72.12	0.53	14.75
Standard. Deviation	16.82	22.58	----	21.71	----	----
School	55.65	68.45	12.80	67.05	-1.40	11.40
Standard. Deviation	15.33	20.62	----	20.30	----	----

*Number shown reflects the number of completed parent PedsQL™ reports received
Differences in scores from Baseline to Year 1 are statistically significant.

- Significant, sustained increases in paying attention in class and keeping up in school activities for these children.

Changes in PedsQL ™ School Functioning Subscale Items for children in the lowest quartile at Baseline.

Subscale Items	Baseline	Year 1	Change	Year 2	Change	Net Change
Paying attention in class	35.00	56.91	21.91	55.13	-1.78	20.13
Forgetting things	60.70	68.50	7.80	66.35	-2.15	5.65
Keeping up in school activities	36.33	59.55	23.22	59.08	-0.47	22.75
Missing school because of not feeling well	72.79	78.18	5.39	77.43	-0.75	4.64
Missing school to go to the doctor or hospital	72.46	77.73	5.27	76.35	-1.38	3.89

Differences in scores from Baseline to Year 1 are significant

- A lack of significant variation by race and language in reports of no foregone care--the most significant variable associated with access.

The percent of sample reporting no foregone care by ethnicity and language at Baseline, Year 1, and Year 2

Ethnicity	Baseline	Year 1	Year 2
White	86.8%	91.5%	93.9%
Latino	84.1%	91.7%	91.9%
African American	83.3%	94.8%	93.9%
Asian/Pacific Islander	83.1%	89.1%	93.3%
Language			
English	84.4%	91.7%	93.3%
Spanish	83.5%	91.2%	91.6%
Vietnamese	80.7%	90.4%	92.6%
Korean	87.0%	92.1%	92.8%
Chinese	86.2%	89.3%	94.4%

The results from this project strongly support the benefits the HFP provides to uninsured children and show that 1) access to care increases significantly for all children, including children who are in the most need of medical care and 2) there is a correlation between improved access and improvement in health status. Reported health related quality of life and improvements in school performance for children who are in the poorest health also increase dramatically. There is virtually no variation by race/language in reports of foregone care--the most important variable associated with access. The largest change in access and in health related quality of life occurred from the Baseline year to Year 1. Gains realized were sustained through Year 2.

There are other factors that may contribute to changes in the health related quality of life which this project could not measure. Factors such as changes in the child's environment and the quality of care provided play a role in whether (or how much) a child's quality of life improves. Aside from these factors, however, analysis conducted by the researchers suggest that access to care, specifically, reductions in foregone care, are important contributors to the improvement in health related quality of life. This is especially true for children in the poorest health at the time of initial enrollment in the HFP.

A detailed description about the measures and results by ethnicity and primary language of the applicant can be found in the *Healthy Families Program Health Status Assessment (PedsQL™) – Revised September 2004 (Attachment VI).* This report is available on the MRMIB website: http://www.mrmib.ca.gov/MRMIB/HFP/PedsQL3.pdf

MONITORING SERVICE DELIVERY AND QUALITY OF SERVICE

Member Surveys

MRMIB uses two types of member surveys to monitor service delivery and quality of service.

1. Plan Disenrollment Survey

   During open enrollment, all subscribers who request to switch health, dental or vision plans are sent a plan disenrollment survey by the HFP administrative vendor. The survey requests information on why members decided to switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers.

2. Consumer satisfaction surveys

   These surveys, based on the Consumer Assessment of Health Plans Survey (CAHPS® 2.0H), are conducted for health and dental plans in five languages (English, Spanish, Chinese, Korean, and Vietnamese). Responses from the surveys provide information on access to care (including specialty referrals), quality of provider communication with subscribers, and members' experience and satisfaction with their providers, health and dental plans and overall health and dental care.

Information about these surveys can be found on pages 39-40, 55 and 58 of the 2005 Federal Annual Report (attached).

Subscriber Complaints

MRMIB receives direct inquiries and complaints from HFP applicants. All HFP inquiries and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the family's primary language and type of request. This data enables staff to:

1. Track complaints by plan;
2. Monitor access to medical care by plan;
3. Evaluate the quality of health care being rendered by plan;
4. Evaluate the effectiveness of plans in processing complaints; and
5. Monitor the plan's ability to meet the linguistic needs of subscribers.

THE YEAR AHEAD

In the 2006/07 fiscal year MRMIB will continue to use the aforementioned methods and reports. Of note are some changes that will be made to the methods and reports:

Health Plan Quality Measurement (HEDIS) report

The HEDIS report will include these additional measures:

- *Use Of Appropriate Medications For Asthma (HEDIS® Measure)*
  The percentage of enrolled members 5 through 18 years of age during the measurement year, who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year.

- *Mental Health Utilization (HEDIS® Measure)*
  The number and percentage of members, by age and sex, receiving mental health services during the measurement year in four categories of service:

- *Well-Child Visits In The First 15 Months Of Life (HEDIS® Measure)*
  The percentage of enrolled members who turned 15 months old during the measurement year, who received either zero, one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life.

Quality Performance Improvement Project

MRMIB is applying a qualitative analysis of HEDIS scores in addressing individual plan quality. MRMIB compared HEDIS 2004 scores with the HEDIS 2003 scores in the following four areas:

- Childhood Immunizations;
- Well Child Visits;
- Adolescent Well Care Visits; and
- Access to Primary Care Physicians,

MRMIB then aggregated scores for these measures, adjusted scores for improvements or declines and established a total plan score. Plans were identified as "high performing plans" or "low performing plans" based on whether their aggregate score was one standard deviation below or one standard deviation above the mean score. MRMIB contacted the high performing plans to discuss strategies and best practices which allowed them to achieve higher scores. These strategies and best practices were shared with low performing plans, which are required to develop a corrective action plan to improve program scores and submit it to MRMIB for concurrence.

Dental Plan Quality Measurement Report

In the coming year MRMIB will again report on dental quality utilizing the following measures:

- Annual Dental Visit,
- 120 day dental assessment,
- Initial Dental Visit
- Dental Sealant per 100 members
- Periodic Dental (Recall) Examinations per 100 members
- Prophylaxis (Dental Cleaning) Service. per 100 members

Consumer Assessment of Health Plans Survey (CAHPS®), Dental Consumer Assessment of Health Plans Survey (DCAHPS®), Youth Adult Health Care Survey (YAHCS)

Last conducted in 2003, the new CAHPS® and DCAHPS® satisfaction surveys will be completed in late 2006. The YAHCS will be conducted for the first time in conjunction with the CAHPS® and DCAHPS®.

YAHCS is a survey given to 14 to 18 year olds to assess how well the health care system is providing recommended preventive care. The survey is administered by mail with an on-line response option and contains 57 questions related to aspects of care. The data obtained from YAHCS can be used for comparisons among plans, other programs and against data from the CAHPS.